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ABSTRACT

This document recognizes the growing awareness of alcohol problems faced by the elderly during the last 10 to 15 years and cites results of studies conducted to examine the extent of these problems. It then presents a community treatment continuum designed by a coalition of concerned individuals in the northwestern part of the United States. The plan described recognizes the fact that alcoholism advances through stages and that treatment needs vary according to the client's position on that continuum. Individual variables that also influence the choice of treatment plan are listed, including economic resources, a living environment supportive of recovery, client personality, and mental and physical condition. A schematic outline is presented which describes each of the continuum's six components of prevention, intervention, detoxification, protected environmental treatment, treatment, and continuing care. A section on components of a community treatment continuum for elderly alcoholics looks separately at these six components and also at the areas of long-term treatment, co-existing mental/physical illnesses which complicate treatment, and social work services. (NB)

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SENIOR ALCOHOL AND DRUG COALITION

STATEMENT OF TREATMENT PHILOSOPHY FOR THE ELDERLY

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INTRODUCTION

There has been a growing awareness of alcohol problems faced by the elderly during the last 10 to 15 years. Although statistics on elderly alcoholism vary widely, Edith Gomberg reported that between 2-25% of our elderly are experiencing problems due to alcohol (1). In surveys conducted in the Pacific Northwest communities of Spokane, Seattle, and Vancouver, Washington, and in Portland, Oregon, figures ranged from 2-19% (2,3,4,17).

A Clark County, Washington, study completed in 1978 found 15% of persons over 60 years of age reported drinking the equivalent of 4 of more drinks daily--an amount that could put an older person at risk for alcoholism, or at least alcohol-related problems. This is a somewhat higher statistic than the household survey percentages reported elsewhere, which range from 2-12% (5,6). According to national statistics, 20-50% of persons residing in nursing homes have alcohol-related problems (7,8). Depending on the setting, from 5% to as high as 60% of elderly men admitted to acute medical wards are active alcoholics, says Dr. Roland Atkinson in his review, "Alcoholism and Drug Abuse in Old Age" (9). The variations in the prevalence rates presented above reflect the difficulty in identifying the extent of alcohol abuse in the elderly. This in part relates to the limitations of data collection methods used and the nature of elderly alcoholism. Professional reporting will often be low because of under diagnosing due to the tendency for the physical and psychological symptoms of substance abuse to be mistaken for symptoms of aging and medical problems. Because of the social isolation sometimes characteristic of the elderly alcoholic, community

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surveys often miss this hidden population. Unfortunately, substance abuse problems are not fully recognized until the debilitating effects of the abuse are profound and an institution or nursing home setting is required. Thus, we see higher prevalence of alcohol-affected elderly in these settings.

If one assumes -- as many professionals in the field do -- that the prevalence of elderly alcohol abuse is at least equal to that found in the general population (10%), then it is striking to note that relatively few treatment programs report serving clients "over-sixty" in numbers that in any way come close to the present "over-sixty" population percentage of 15-18%. In Clark County, Washington, during 1978, less than 0.5% of persons over 60 were seen in Washington State alcoholism treatment programs. Likewise, during the 1985-86 fiscal year, only 0.001% of the total clients served in Oregon's publicly funded alcoholism treatment programs were 65 or older. Yet this same age range makes up 13% of the state's population.

In September, 1985, a coalition of concerned persons* in the Portland-Vancouver area met to assess the current local situation and to make recommendations. Based on a review of the literature available and the experience of coalition members who have worked as clinicians with elderly alcoholics, a community treatment continuum was designed. The plan recognizes the fact that alcoholism advances through stages and that treatment needs vary according to the client's position on that continuum.

* Rita Boyd, Clackamas County Mental Health/ Gloria Burger, Multnomah County Alcohol and Drug Program/ Jean Dunlop, Laurelhurst Manor/ Lynn Falkow, Tri-City Health Care Center/ Betty Glantz, Multnomah County Aging Services Division/ Don Manghelli, Good Samaritan Hospital/ Jim Peterson, Washington County Mental Health/ Bob Tolson, Veterans Hospital in Vancouver/ Arlene Slive, Southwest Washington Area Agency on Aging.

Individual variables also influence the choice of treatment plan. These variables include economic resources, a living environment supportive of recovery, client personality, and mental and physical condition.

The continuum includes the following six components: Prevention, Intervention, Detoxification, Protected Environmental Treatment, Treatment, and Continuing Care. A schematic outline is presented with a description of each component.

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SCHEMATIC OUTLINE

TREATMENT CONTINUUM FOR ELDERLY ALCOHOLICS

PREVENTION	INTERVENTION	DETOXIFICATION	PROTECTIVE ENVIRONMENTAL TREATMENT	TREATMENT	CONTINUING CARE
1. Education of pre-retirement ages 2. Education of retired persons 3. Crisis support during trigger events such as retirement or loss of a spouse 4. Education of "gatekeepers" (mail carriers, grocery clerks, etc.) 5. Education of professionals: Health Care and Senior Services Providers 6. Community awareness of "stressors" of the elderly and programs to address these stresses	1. Need for making a differential diagnosis: symptoms of alcoholism masked by symptoms of aging 2. Treatment seen as the recommended option for most 3. Seductive versus confrontive/coercive approach 4. Family education about disease concept and resources 5. Need to consider individual variables: _A_ Economic resources _B_ Supportive environment _C_ Personality _D_ Medical condition _E_ Mental status _F_ Stage of disease	1. Longer time frame for management of acute and prolonged withdrawal 2. Medical versus social detoxification, need for medical monitoring 3. Need for ongoing assessment of reversible versus irreversible mental and physical effects of the disease 4. Educate family about options and expectations for treatment and recovery	1. Used as pre-treatment, this is a residential phase in an adult foster home or half-way house where there is protection from alcohol and early mental and physical recovery may begin 2. This phase may also become continuing care for those with significant cognitive impairment	1. Outpatient peer group for: _A_ Long term assessment and increasing motivation for sobriety _B_ Primary treatment in selected cases where there is environmental support for recovery _C_ Continuing care 2. Inpatient: _A_ Freestanding residential _B_ Hospital-based residential 3. Need for peer age group during primary treatment where clients relate more easily and feel freer to self-disclose 4. Family treatment	1. Half-way house or adult foster home for continued protection from alcohol following primary treatment and prior to independent living 2. Peer group, open-ended, for on-going support for sobriety 3. Family involvement, e.g., family group, conjoint activities 4. Over-55 A.A., Al Anon 5. Help with transitioning to senior activities in the community, broadening social skills in sobriety 6. Use of Outward-Bound type of program to build trust in self and others

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COMPONENTS OF A COMMUNITY TREATMENT CONTINUUM FOR ELDERLY ALCOHOLICS

I. PREVENTION

Primary prevention tactics for the alcohol abuser of late life must begin early. All levels of society must be made aware of the dangers in using alcohol and drugs as a coping mechanism for the realities and difficulties of life. In order to accomplish this awareness, values which encourage a healthy life-style are needed.

Many social drinkers and even some abstainers become problem drinkers or alcoholics late in life in response to life's stresses. Prevention needs to focus on those situations which can produce alcohol misuse or alcoholism for some. People need to be educated about the problems produced when one uses the "quick fix" of alcohol or pills to deal with life's problems. Two common trigger events have been identified repeatedly in programs serving elderly alcoholics. These events are death of a spouse and retirement, both leading to an altered self-image having to do with the loss of one's accustomed life role. Resulting feelings of emptiness and loss of purpose have been "medicated" with alcohol which for some has led to increasing loss of control and eventual alcoholism. Other causes of stress for the elderly include self-concept issues found in ageism, dealing with poverty, and the sense of uselessness when we think of being old as "out to pasture" or enforced idleness in a rocking chair. A lack of meaning may come from a feeling that one "should" have lived one's life differently. Prevention programs need to teach awareness of such "trigger" events and of healthy ways to cope with these stresses.

In addition to the teaching of stress management, prevention includes raising awareness on the part of society of the need to alleviate some of the

above causes of stress which are avoidable. Counseling needs to be available to older persons faced with life crises along with an adequate income provided in a mode to allow a life of dignity and self-reliance. Finally, our older population needs to be seen as a resource and useful roles developed which foster dignity and give meaning to life.

Secondary prevention refers to intervention in the early stages of developing alcoholism before serious problems arise (10). Prevention at this stage needs to be directed at education for the natural support system. Physicians, nurses, clergy, social workers, senior service workers, managers for the elderly, and others in a front-line-position to recognize alcohol problems need to be taught signs and symptoms and how to intervene.

II. OUTREACH AND INTERVENTION

Outreach and intervention services are of critical importance for older alcoholics due to the hidden nature of their problem. Major obstacles to the accessing of help, besides the frequent denial of the client, have been lack of recognition of the problem by those close to the alcoholic, negative attitudes such as hopelessness and helplessness, and lack of the coercive forces that operate for younger alcoholics and addicts (such as those of the boss, family, or legal system). A mobile staff trained in making a differential diagnosis who can make client home visits, do accurate assessments, and provide skilled intervention services will facilitate the beginning of appropriate treatment for elderly alcoholics at any stage of the illness.

It is important that the interventionist or person recognizing the

alcoholism understand that alcoholism treatment is the recommended option for most. To treat the results of the alcoholism with the provision of various senior services, or medical care, or financial assistance without addressing the alcoholism will not only be useless, but will also enable the alcoholism to continue. Older alcoholics seem to respond to treatment at least as well as younger clients and particularly well if their unique needs are addressed (9,10,11,12,13).

A strong stigma against alcoholism exists which is very powerful among the elderly generation. This stigma re-enforces the denial commonly seen in alcoholism in any age. There is thus a need for intervention to be done via the seductive rather than the heavily confrontive/coercive approach often used with younger addicts. The lack of coercive forces as mentioned above, as well as more profound loss of ego-strength, combine to make negative confrontation ineffective and even damaging to the older alcoholic. An intervention characterized by the building of self-esteem and carried out in a supportive manner has a greater liklihood of success (13,14). For those persons whose resistance and/or denial prevents the use of help offered, a committment law in Washington state has been found to be useful. A person may thus be found to be a danger to himself or others due to alcoholism and committed to treatment via the legal process.

Family education at this point can begin treatment for the entire family system by fostering understanding early in the treatment continuum. Family members need awareness of their tendency to inadvertently enable the alcoholic to drink by interfering in the natural consequences of the drinking, mistakenly believing they are helping. Alcoholics need to experience the negative

consequences of their drinking in order to see a reason to stop. The distinction between enabling and offering help is a difficult one to make in the case of older persons who often need assistance due to losses caused by the aging process itself.

III. DETOXIFICATION SERVICES

There is frequently a need to provide a longer period of time for detoxification due to the lessened ability of the elderly to tolerate physiological of psychological stress (15,16). If treatment is to be tailored to individual needs, there must be the availability of both medical and non-medical detoxification care with a flexible time frame to be determined by the monitoring of vital signs and other physiological and psychological symptoms. These services in most cases should be provided in a residential medical or non-medical setting where there is protection from alcohol.

There is also a need for on-going assessment of reversible versus irreversible mental and physical effects. Consistent with the general principals of medical gerontology as well as in the experience of Senior Alcohol Services (17), recovery from the reversible effects of alcohol may continue for as long as two years or more. The time is variable and relates to the time of onset of the alcoholism as well as to individual factors.

It is also important to educate the family as to the prolonged recovery process so that expectations may be realistic. Options for primary treatment and living arrangements should be presented.

IV. PROTECTIVE ENVIRONMENTAL TREATMENT

For many older clients there is a need for housing which can provide protection from alcohol and support for sobriety on a flexible time frame both prior to and immediately following primary treatment. Such a setting would allow for maximum benefit from treatment because a client could have recovered greater mental functioning and physical strength prior to entering treatment programs. Likewise, it could provide for the needs of the slowly recovering person following treatment, allowing for more gradual transition to independent living.

V. PRIMARY TREATMENT

This phase of treatment could be provided in an outpatient setting or in a residential free-standing or hospital-based setting, depending on the stage of illness, co-existence of other medical/psychological problems, amount of social support such as family and friends available, and the degree of individual motivation for sobriety. It has been demonstrated that on-going outpatient continuing care peer groups can be used successfully as primary treatment for some clients (12,13). This intensive phase of treatment should be available within varying time frames ranging from two to six weeks for residential, or eight to twelve weeks or longer for outpatient programs.

If the treatment setting is a program treating all ages, the unique needs of the elderly may be effectively addressed by the provision of cohort groups. These may meet in place of, or in addition to, the all-age groups. The issues of older patients can best be worked on in an atmosphere in which the gentle supportive approach is used rather than the heavy confrontation often applied in working with the younger addict. Self-disclosure in a group comes with

great difficulty -- if at all -- for most elderly clients. In some cases there is then a need for one-to-one counseling to be sure that important but intimate issues are worked on. For successful treatment outcome, it is essential that staff be sensitive to the special needs and characteristics of the older client.

Awareness of the slower physical and mental pace, various sensory deficits, short-term memory impairment, dislike of profanity in mixed groups, and a much longer time frame for recovery allow for realistic expectations for staff and client.

The use of outpatient peer age group for assessment and motivation for sobriety, as well as for primary treatment and continuing care has been in innovative program at the Portland-Vancouver V.A. Hospital (13). Such a treatment program could be extremely cost-effective for many elderly who have been assessed to have some motivation, relatively few medical/psychological problems, and at least a minimal social support system. An alcoholism counselor trained in geriatrics would be a minimum staff requirement.

Family members of older alcoholics have treatment needs also. Common family responses seen among the adult sons and daughters of alcoholics vary between total estrangement and loving attempts to control...with angry efforts to punish or attempts to overprotect falling somewhere between. Elderly spouses "enable" out of a long-time sense of duty. All family members need help along all the stages of the treatment continuum.

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VI. CONTINUING CARE

Following the primary intensive phase of treatment, there is need for regular, frequent, and open-ended outpatient peer groups and one-on-one counseling services. Peer groups should be available at least two or three times weekly for support of ongoing sobriety. These groups provide a milieu in which social skills may be recovered and enjoyed as well as providing support for sobriety. Much social bonding occurs when such a forum is provided. Such groups could be provided in a variety of settings, such as senior centers, elderly housing facilities, community centers, as well as in identified alcohol/drug treatment programs. We are aware that many senior center participants have a negative attitude toward "alcoholism" which would be a serious problem in the effective use of buildings housing senior programs. If this negativity could be overcome however, these locations would offer convenience, accessibility, and important contact with other senior activities which would offer alternatives to drinking during continuing recovery.

Over-55 A.A. groups are an important addition to treatment at all stages and an easily available support which is especially helpful during continuing care. The recovery needs of family members should be addressed during this phase by provision of family groups as well as conjoint or couples groups. Al-Anon and A.C.O.A. are also highly recommended for recovery of spouses as well as adult sons and daughters.

VII. LONG TERM TREATMENT

For the late-stage, older alcoholic client who suffers from medical complications and/or dementia, we believe a long-term residential treatment

facility is appropriate. Relatively few programs meet the needs of the person whose alcoholism has caused these serious complications. Such a program would provide for basic needs such as housing, along with protection from alcohol, a nutritious diet, and medical care when needed. In addition, a low-key, slow-paced alcoholism treatment program would be provided with information about alcohol presented simply, briefly, and repetitiously in a variety of ways. The general milieu would focus on strong peer and staff support for abstinence from alcohol. The long-term goal would be either eventual independent living in sobriety, or continued sobriety in another protected environment.

VIII. CO-EXISTING MENTAL/PHYSICAL ILLNESSES WHICH COMPLICATE TREATMENT

Treatment programs are needed which can address the needs of alcoholic persons afflicted with co-existing conditions such as psychosis or physically debilitating diseases. Persons suffering from dual disorders have specialized needs not addressed in current treatment settings, and are an underserved population. Presently, they are often treated in medical or psychiatric settings for the co-existing condition while the chemical dependency goes undertreated or not treated at all.

IX. SOCIAL WORK SERVICES

Throughout the treatment continuum, there is need to provide an ongoing holistic assessment of all areas of the client's life. Case management should be available to those more fragile and isolated elderly whose recovery will be at risk without it. An outreach component of social work service is, thus, essential.

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